DEPARTMENT OF PERIODONTOLOGY

FLAP OPERATION

INFORMED CONSENT FORM

File Number: **BARCODE**

Patient Name-Surname:

Dear Patient / Legal representative;

The purpose of this CONSENT form is to ensure that you are informed in writing and verbally about the possible side effects that may be encountered during all procedures/applications to be applied for your treatment, to document that you accept the examination and treatment by knowing these, to obtain your consent and signature.

- Once you have learned about the benefits and possible risks of medical treatment, it is up to you to decide whether or not to consent to the procedure.
- Before starting treatment, it is important that you inform your dentist/physician about any systemic, infectious or contagious diseases or allergies you may have;
- Although the success rate of all treatments is very high, it should be known that it cannot be guaranteed, so the treated teeth may need to be extracted, and the treatment and the disease may recur in the future.
- If you wish to exercise your right to refuse or terminate treatment, please inform your doctor.
- If necessary, you can reach the clinic where you received treatment/procedure during working hours (8.30-16.30) by calling 0246 211 33 47 for medical assistance.
- This form is issued in two copies; one copy is given to the patient. If the procedure has not started even after your approval, you have the right to withdraw your approval.
- For your opinions, suggestions, thanks and complaints about our services; you can apply to the patient rights unit, you can throw it in the wish-complaint and suggestion boxes in our center, you can send it to us from the Write to Us section on our website.
- **Diagnosis/Pre-diagnosis:……**

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18	17	16	15	14	13	12	11	21	22	23	24	25	26		27	28	
48	47	46	45	44	43	42	41	31	32	33	34	35	36		37	38	
			85	84	83	82	81	71	72	73	74	75					

CONSENT DOCUMENT FOR FLAP OPERATION

Definition of the Procedure: In cases where periodontal disease progresses, surgical operation (flap) may also be required after scaling and root planing procedures. The surgical procedure begins with local anesthesia in the operation area. Then, an incision is made with a scalpel on the gum in the operation area and the gingival flap is elevated. Inflammatory tissues around the roots are removed. The root surface is planed with hand instruments, if necessary, bone correction is performed and the gingival flap is shaped in accordance with the bone and then sutured. If necessary, biomaterials such as bone grafts and membranes are applied to rebuild bone around the tooth. Antibiotic treatment may be given if deemed necessary by the physician. Sutures are removed after 7-10 days.

By whom and where the procedure will be performed: The procedure will be performed by the faculty members of the Department of Periodontology and dentists in postgraduate education (doctorate or specialty) and in the Periodontology Clinic.

Expected Benefits of the Procedure: Complete cleaning of root surfaces and pocket depth reduction is the main goal. After the operation, pathological pocket depths are reduced or eliminated. This facilitates the patient's home care and the physician's professional controls and makes it possible to maintain periodontal health. The patient can preserve his/her natural teeth and is protected from general health problems caused by infection from the pockets.

Possible Side Effects, Risks and Complications: Local anesthesia (with spray, gel or injection) is applied during treatment. Mild pain may be felt during the treatment. Gingival treatment may require the removal of existing dentures and replacement of these dentures with new ones after gingival treatment. Pain, bleeding, mild

swelling, abscess or skin discoloration (ecchymosis) may occur in the first 3-4 days (to prevent these, the doctor's recommendations should be followed to the maximum extent). The sutures placed in the operation area can be opened. As the gingiva heals, gingival deformities may occur. Depending on the severity of the gingival disease, conditions such as formation of gaps between the teeth, gingival recession, and easier accumulation of food between the teeth may occur. After the treatment, air intake, hot-cold sensitivity may occur in the teeth. During the treatment, there may be a temporary increase in mobility of the teeth. Mild pain may be felt when pressed on the teeth. The response (healing) of the gingiva, which is a living tissue, to the treatment varies from patient to patient. Therefore, there may be cases where there is no response to the treatment and repeated sessions may be required. After some gingival treatments, it may take 3-4 weeks for the tissues to repair. For this reason, it may be necessary to wait up to 1 month for prosthetic treatment after gingival treatment. After the necessary gingival treatments, the first follow-up appointment is made after 10 days and the following follow-ups are usually made at 6-month intervals. As a result of this treatment, there may be complete recovery, or periodontal surgery may need to be repeated if deemed necessary.

Estimated Duration of the Procedure; 30-90 minutes including anesthesia.

Problems that may be encountered if the procedure is not performed; Gingival disease continues in the area where the teeth are located. Depending on the progression of the disease, increased mobility of the teeth, decreased chewing function and tooth loss may occur in the later period. Unhealthy periodontal tissues also negatively affect general health. It is known that people with many diseases such as cardiovascular diseases, diabetes, kidney diseases, miscarriage during pregnancy have impaired periodontal health.

Critical Lifestyle Recommendations for Health: Read and follow the list of things to be considered after the operation. After the surgical procedure, do not eat or drink anything until the effect of local anesthesia wears off (approximately 2-4 hours). You should stay away from hot food and drinks in the first 24 hours after the operation. Chewing should be done with the area not included in the operation. Soft and warm foods are suitable. Acidic fruit juices, alcoholic drinks and spicy foods should be avoided. Otherwise they will cause pain. In the days following the operation, smoking should be avoided as it will irritate the gums, jeopardize healing and increase the temperature inside the mouth. For 2 weeks following the operation, removable prostheses, if any, should be used as little as possible. The lip and cheek should not be lifted to look at the stitches in the operated area. There may be slight swelling. You can prepare an ice pack and apply it externally on the operation area on the first day. There may be some leakage from the surgical site in the first 4-5 hours after the operation. This will give your saliva a red color. In this case, do not panic and if the leakage continues, you can roll a clean gauze pad and apply it to the bleeding area for about 20 minutes. In case of longer bleeding, consult your doctor. You may feel chills and weakness in the first 24 hours after the operation. This is normal and there is no need to worry. You can continue your daily activities, but sports that require excessive effort should not be practiced. Follow your doctor's prescription for recovery after the operation. If your doctor recommends antibiotics, use them as prescribed. If you have pain after the operation, you can take painkillers. In this case, aspirin or similar salicylic acid derivatives should not be taken. You can apply normal brushing procedures to the non-operated areas. Brush the chewing surfaces of the teeth in the operation area. If the pat has not been applied, you can also brush the teeth in that area. However, do not go under the gingiva when flossing. If your doctor recommends, you can use the recommended mouthwash after brushing.

Alternative: No periodontal surgical procedure other than tooth surface cleaning and root surface smoothing and frequent check-ups.

APPROVAL:

During diagnosis and treatment, the dentist may ;

Consultation can be requested from other physicians and these physicians can participate in the treatment process,

Oral, Dental and Maxillofacial Radiology doctors, trainee dentists, dental technicians and x-ray technicians can take films,

My anamnesis information and radiological images, photographs, examination results (pathology report, laboratory results, etc.) may be used for diagnostic, scientific, educational or research purposes by keeping my identity information confidential,

During the diagnostic method, intervention or treatment, local anesthesia may be applied as part of these procedures, attending the appointments without interruption and complying with the physician's recommendations and practices regarding the treatment may directly affect the treatment results, it was explained to me.

Patients Abbreviated Signature

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I was informed about the Implementation Communiqué published by the Social Security Institution (SSI) for the relevant treatments. I was informed that the invoices for the items that the SSI does not pay for the material to be used during the stages of the treatment must be paid by me

I know that I have the right to refuse or terminate treatment. I find all verbal and written information sufficient. I have read, understood and approved the "Informed Consent Form" for all examinations and treatments to be performed.

Dear Patient, You have the right to be informed about your health condition and the benefits/harms, risks and alternatives of the proposed diagnostic or therapeutic procedures; to accept or partially/completely reject the treatment; and to stop the procedures at any stage! This document, which we want you to read and understand, has been prepared not to scare you or to keep you away from medical practices, but to inform you, to determine whether you consent to these practices and to obtain your consent. This consent form consists of 3 pages and has been prepared in 2 copies in accordance with Article 70 of the Law No. 1219 and Article 26 of the Turkish Criminal Code No. 5237, and one copy has been given to the patient/patient's legal representative.

I HAVE BEEN INFORMED ABOUT THE TREATMENT RELATED TO MY ILLNESS, **AND I HAVE READ AND UNDERSTOOD THIS FORM. I ACCEPT THE TREATMENT**

(Note: This statement will be printed below in the patient's/family member's **OWN HANDWRITING**..)

…….

THE NAME AND SURNAME OF THE PATIENT/PATIENT'S RELATIVE/ PATIENT'S GUARDIAN:……	THE NAME AND SURNAME OF THE PHYSICIAN PROVIDING THE INFORMATION.
DATE:……	…..……
TIME:……..	DATE:…….
	TIME:……..
SIGNATURE	SIGNATURE

Patients Abbreviated Signature